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Original Department.

Lecture.

CLINICAL LECTURE.

elivered in Bellevue Hospital Medical College,

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REPORTED BY WILLIAM A. GEORGE, M.D.

Talipes.

Gentlemen:—In our last lecture I spoke to you of deformities of the feet. I told you that *talipes equinus* was that distortion of the foot in which the heel was elevated; *talipes calcaneus* in which the heel was depressed; *talipes varus* in which the foot was inverted, and *talipes valgus* in which the foot was everted. Perfect examples of any of these forms of talipes are of infrequent occurrence, the deformity nearly always partaking of the character of two varieties. [The professor here referred to several plaster casts illustrative of the different forms which talipes assumes.]

I told you at the time cases were divided into (1) congenital, and (2) acquired; those from birth and those acquired by subsequent disease, the result of nervous inanition. Talipes, in the great majority of cases, is the result of paralysis.

Now, how are you going to detect whether the disease is of paralytic or spastic origin? If it be the result of paralysis, it can be restored by the hand to its proper position, but as soon as you remove your hand it goes back to its former place. If it be of spastic origin, you will not be able to restore it to the normal condition, and in order to do this, you must sever the tissues that hold it in the abnormal state. In cases of paralytic origin of long standing, inflammation may take place at spots pressed upon, and thus produce reflex contractions of other tendons which may require section to effect a cure. And right here I want to impress upon your minds a physiological law; structural change is the inevitable result of long continued contraction.

Next, how are you to decide whether you must cut or not? If you can, by the moderate application of force, long continued, gradually restore the foot to its normal position, and, holding it there, touch the tendon stretched, and it does not produce a reflex spasm, then that tendon must not be severed; if, on the contrary, pressure does induce reflex spasmodic contraction, then cut.

Having discovered that there is a necessity for making section of a tendon or fascia, where shall you cut? It is in the exact spot where by pressure you produce this spasm, whether it be in the tendo-achillis or anywhere else; the point of pain is the place for incision.

And now, how are you going to cut? In the first place you want tenotomes of a different pattern from those found in any of the shops, and the proper instrument for this operation I hold in my hand; a knife, with a strong sickle-shaped blade, and firm handle, so as to avoid all danger of breaking, is the one you most frequently use. The blade is rounded upon the point, chisel-shaped, that there may be no risk of puncturing an artery, a risk too dangerous to incur. Always in cutting deep-seated tendons it is best not to use a pointed blade. There should, also, be a dot on the

handle of the knife, to indicate to you upon which side the edge is. Having selected your tenotome, holding it flatwise, you slowly pass it through the integument, gliding along toward the tendon you intend dividing (which will readily be recognized the moment you strike it), enter the theca, slide the knife under the tendon, and turning its edge upward toward the tendon, making firm pressure at the same time upon the latter against the knife, you gradually saw your way through. The moment the tendon snaps, cut no more; turn the blade upon its side and withdraw, being careful to place your thumb on the wound to exclude air, and hermetically seal with adhesive plaster. It is possible you may have cut vessels by this wound, but the blood effused will soon be absorbed.

You now apply the following dressing:—Take a piece of board a little longer than the patient's foot, and saw it into the shape of the sole of the foot; then cutting a strip of adhesive plaster twice the length of the board, and to extend from the toes to the knee and reverse, you commence at the anterior extremity of the board and apply the plaster, running along the upper surface, passing over the heel and then forward, leaving the remainder of the strip for future use. Now place the heel of the child on the heel of the board, and firmly secure it there by a strip of adhesive plaster across the instep, being careful to nick it so as to prevent strangulation and its consequence, sloughing. After fastening the heel in this manner, you bring the foot into its normal position, and hold it there by adhesive straps and roller, taking care in their application not to interfere with the circulation, as the temperature is always low, and it will not bear pressure as well as in a healthy condition. Now the strip of plaster at the toe of the board is brought up and attached to the leg below the knee, and the roller, being carried half way up the leg, is passed over it; then the end of the plaster is reversed and the roller passed over again to make it the more secure. In two or three days' time take the dressing down and examine; relieve pressure where the limb has been bruised and readjust the dressing as before. After four or five days the wound will be completely healed, when you will employ whipping, galvanism, and manipulation, until you restore the foot to its normal position. You must use caution not to overdo these manipulations so as to tire the muscles, and in your plan of electric treatment be careful not to exhaust, but to stimulate the parts; do not drive the paralyzed muscles beyond their endurance.

[The Professor then illustrated the plan of treatment by adhesive straps and Barwell's method of cure by the use of artificial muscles. He spoke of a test to discover whether a muscle had undergone any structural change, which was on the principle of testing butter or flour, and consisted in passing a tubular instrument through different portions of a muscle, and subjecting the tissues which had become impacted in the tube to a microscopical examination.] "If it be thoroughly and completely changed in its structure, from one end to the other, then it is gone."

Case 1. I bring this case before you, gentlemen, to illustrate two or three points in the after-treatment. You will remember I operated upon this boy some two weeks since, for club foot, and the result has been eminently satisfactory. A mistake, however, has occurred in the manufacture of his shoe, which has happened, also, upon several other occasions, and in regard to which I desire you to be on your guard; viz., the shoe has been made too short. In cases of operation for talipes the foot becomes extended and expanded, owing to the section of tendons and fascia which bound it in its abnormal position, so that if allowance is not made for this extension and expansion in the manufacture of the shoe, it will prove too small.

There is another point connected with the dressing of this foot to which I desire to call your attention; I refer to the irritation and swelling which is produced by leaving a thread of raveling between the integument and bandage. It is astonishing to see how much injury can be wrought by inattention to this apparently insignificant matter. It will frequently upset the most perfect surgical operation if not looked after.

You will notice now, when I make pressure upon the tendon divided, that I do not produce the spasm which I was able to before; but you will also perceive that it still requires mechanical appliances to retain it in its proper position, but only the slightest amount of force is requisite for this purpose. What I wish to impress upon you, is, that notwithstanding I have employed all the surgical interference necessary in the case, the boy is not *cured*, and

is but ready for the only fit treatment. His difficulty was *varo equinus*, of the very worst form, still, had it not been for the raveling before referred to, he would not have required the dressing removed at all. You will notice the waste of this little fellow's limb, and it is not until the muscles are restored by friction, shampooing, electricity, etc., that he should be permitted to walk without some mechanical means to keep the foot in its normal condition. This shoe furnishes that means. It has a ball-and-socket joint opposite the medio-tarsal articulation, and also a joint at the ankle; it is not cumbersome, does not girdle the limb, thereby interfering with the circulation, and is arranged for the application of elastic power. Prof. Crosby has contrived a cheap and useful substitute by cutting through the sole of a common shoe just in front of the heel, securing the two parts by two wire links, thus furnishing movement at the medio-tarsal articulation. In putting on the bandage, great care should be taken to prevent strangulation, and in a little child, where the skin is tender, it is sometimes well to put on the bandage first, before putting on the plaster.

Case 2. Here, in this little girl, we have a case of *equino-varus* complicated with *genu-valgum*, or knock-knee, in the left leg. You will remember I divided, a week since, the tendo-achillis and plantar fascia, and then, in order to bring the knee straight, put a board on the inside of her thigh and bound it there by a rubber strap, and you will observe the good results derived from one week's application of continuous force. The child, the father says, has been perfectly quiet, slept well at night, and caused no trouble whatever, something unusual in the treatment of this complication.

We will examine now if the foot has sloughed. If I have made any mistake it will be your gain. We will first see how much damage has been done to this tendo-achillis. It is all perfectly beautiful. Now let us look at the other wound. You may all, perhaps, see this black line running across the bottom of the foot, which is the line of section of the plantar fascia, and you will perceive when I have her foot fully extended I make my point pressure and receive no reflex contraction in return, showing that the spasm has been entirely cured. The external wounds have healed, but I will cover them over with a strip of plaster for a few days longer, and instead of putting on the foot-board as I had it before, I now simply take a long strip of adhesive plaster, as you observe, commencing on the outer side of the dorsum of the foot, draw it over the inner side of the dorsum of the foot, then over the plantar surface, and finally up the outer side of the leg, pulling it well up on the calf, and secure with a roller.

The trouble in this child is going to be with the knee. She will require to wear an instrument for the purpose of everting the knee, which will, doubtless, have to be applied for many months. [The professor here adjusted a long, straight, leather splint, moulded to the outer side of the leg, extending from the trochanter to the junction of the lower and middle third of the tibia, well padded, and secured above close to the thigh, but below projecting some little distance from the leg. A strip of adhesive plaster was then fastened around the splint and leg at the knee, the patient's own feelings being the guide in tightening it, and over all was slipped an inch elastic band.]

Case 3. In this little babe, gentlemen, we have a case of double equino-valgus, which has been cut, followed by sloughing. One of the feet, however, has been straightened by the application of elastic force, and in the other I purpose dividing the tendo-achillis and plantar fascia. You probably all heard that snap (referring to section of plantar fascia), and if the young one will stop crying you will hear the snap of the tendo-achillis. Now the foot is very readily placed in position. I will wait, and watch this plaster a moment, to see if I have it too tight. You will notice I nick this strip running over the ankle, for when I bind the foot up it will require more room at that point than now. I am not at all surprised that the doctor had sloughing in this case, for notwithstanding I have divided this fascia and tendon completely, the integumentary and connective tissues are so tense that it is with great difficulty I can bring the foot into its proper position. I have brought it to a right angle, showing that it is possible, but content myself to reduce the parts to their normal condition by degrees. This is a complicated case, and I am glad that it has happened to be so, that your attention may be called again to the dangers of which I have warned you, and for which you must always be on your guard. I cannot restore it perfectly at once, and we must be content for the present with the good we have effected. Nor can I leave this child as long as

the one we had last week, before inspecting the dressing. It may be necessary to re-dress the foot within an hour, depending, of course, altogether on the condition of the circulation. If I put the bandage on too tight we may lose the foot.

COMMUNICATIONS.

CLINICAL OBSERVATIONS, WITH CASES OF DISEASES OF THE RETINA, AND ON THE USE OF A NEW REMEDY FOR THE TREATMENT OF AMBLYOPIA POTATORUM.

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In no department of the healing art has a more positive advance been made than in the knowledge of the various causes of blindness. Since the discovery and application of the ophthalmoscope, obscure diseases of the eye, comprised under the head of *amaurosis*, can now be so thoroughly understood that they are classified into those in which remedies are useful, nay, specifics, and those in which they are useless, even injurious; to say nothing of operative interference, in many cases so absolutely necessary to the restoration or preservation of sight. Divisions are now made into diseases of the several investing tunics, and tumors; viz, sclerotic, cornea, choroid, iris, ciliary body, retina (expansion of the optic nerve), vitreous humor, and crystalline lens, each portion being subject to particular diseases, with characteristic symptoms and appearances.

In this short paper we purpose to treat of some forms of disease of the retina, and commence by hinting at its anatomy and physiology The retina is the membranous expansion of the optic nerve found in the posterior surface of the eye, its posterior surface being in contact with the choroid and its inner surface with the vitreous humor. It consists of ten layers,* enumerating from within outward, according to Max Schultze, of elements of nerve tissue and connective or basis substance; but how they are respectively distributed has not as yet been made out. The optic nerve perforates the sclerotic a little to its inner or nasal side, at the so-called *lamina cribrosa*, and is next seen in a corresponding position, as the *optic disc*, which is generally circular in form, and of a grayish pink tint, frequently varying in shape, color and size. The vessels of the retina arise from the ophthalmic artery, and generally emerge from the central portion of the disc, or somewhat to the inner side of it, their number, mode of division and course varying, being constant only in this, that the principal branches run upward and downward over the retina, where the light pink arteries and purple veins may be distinctly seen with the ophthalmoscope. In the centre of the posterior part of the globe, to the outer side of the disc, is the yellow spot, or macula-lutea, in the centre of which is the fovea centralis, with which part we see most distinctly, and at which point the most vivid impressions are received. As there are only conducting, and no percipient elements in the disc, it constitutes what is known as the "blind spot."

The rods and cones of the retina receive the undulations of light, and by some molecular change communicate the impressions through the optic nerve to the brain, somewhat similar to the sense of touch. If, therefore, the surface of this beautiful and delicate film is impaired, clouded, or in any way altered, by inflammation or otherwise, it prevents that perfect passage, impression or conduction of the waves of light, and blindness more or less intense is the consequence.

Retinitis.

This name is given to one of the first changes, by inflammation, noticeable in the retina, and is frequently the result of exposure to heat and light, intense application or study, especially where the accommodation or refraction is defective, and often follows as a consequence of diseases of the choroid, ciliary body and iris. The abuse of alcohol as well as tobacco is a frequent cause, as well as such local causes as inter-cranial or orbital tumors; it is also dependent upon disturbances in the general circulation, as by affections of the heart or liver, or again, increase in intra-ocular tension (glaucoma).

If the fundus of such an eye be examined with the ophthalmoscope, there will be found an

* 1. Membrana limitans interna.
2. Layer of optic nerve fibres.
3. Layer of ganglion-cells.
4. Internal molecular layer.
5. Layer of internal granules.
6. External molecular (intergranular) layer.
7. Layer of external granules, including the external fibrous layer which exists in certain portions of the retina.
8. Membrana limitans externa.
9. Layer of rods and cones.
10. Pigment layer.

opacity covering more or less of the retina; the arteries generally show no particular change; the veins are, however, enlarged and tortuous, with now and then small extravasations of blood upon or close to them. Still later the serum becomes separated from the blood, this effusion into the vitreous almost covering the optic disc. Many other changes which mark the characteristics of the various forms of retinitis are too numerous to mention here.

The patients generally complain of a cloud or gray film before their eyes, which dimness is apt to increase, and, halo-like, surround objects more and more, until they become obscured. The external appearance of the eyes, nevertheless, remains the same as if normal and healthy. If properly treated by (cold) absorbents, rest, and salts of potash, with local depletion, there follows, in the course of a few weeks, the clearing up of the vitreous, the papilla once more being distinctly seen. The blood is soon absorbed, generally leaving, however, a deposit of pigment, a white cicatricial or atrophic spot, to mark its former site, and vision more or less perfect is restored. If neglected, intense inflammation, with great pain, generally follows, at times involving all the structures and totally destroying the organ. Be careful, in your examination of individuals of a dark and swarthy color, not to confound a natural increase of the pigment, and frighten your patient by informing him that he is about to lose his vision.

Retinitis Syphilitica.

This is another form of this disease, and is due to a certain morbid poison received into the system, for instance, syphilis, both hereditary and acquired, and is generally known as *retinitis syphilitica*, which I regret to say is becoming much more common of late, keeping pace, as it were, with wealth, indolence and vice. There is a great increase in the number of young men who now suffer from constitutional syphilis, and if it makes its appearance in the eyes, it is apt ultimately to assume the form just mentioned. We often see it accompanying secondary symptoms, following an iritis, choroiditis, or indo-choroiditis, and not infrequently involving the optic nerve.

Ophthalmoscopically the affection may be distinguished by the peculiar and characteristic appearance of the fundus, the several pictures, however, being most varied and interesting. So far as our experience goes, the iris has been the first portion attacked, and after the iritis has run its course (which latter we must here remark is very uncertain), the pupil dilates, and we are enabled to secure a glimpse of the interior (but we must not neglect in this connection to state one important diagnostic feature, that is, where circumcorneal redness remains persistent, after the other symptoms of an iritis have passed, we invariably suspect intra-ocular changes). The vitreous may be so clouded that we cannot obtain the faintest reflex, or else we see the fundus presenting the changes we are about to describe. The retina, particularly in the neighborhood of the disc, is of a bluish-gray color, not unlike the normal color of the retina of the colored race, with white or grayish-white stripes or bands running from above, downward over its surface; minute punctiform opacities, or irregular circumscribed spots or patches of a pink or gray color, sometimes snow white, and glistening, being seen upon all parts of the fundus. These spots or patches are frequently seen in clusters, from the disc to the periphery, at times encircling the yellow spot, and almost always surrounded by dark zones of pigment, or having a fringed indistinct outline of the same substance.

One peculiar feature of the disease is that these changes in the fundus cannot all be seen unless the cases are examined frequently, as they disappear and reappear from time to time, the sight fluctuating accordingly; nevertheless the skilled ophthalmoscopist can frequently make his diagnosis with no other than the above described appearances. If the acute process is not checked, the changes become permanent, and atrophy of the optic nerve is the result; it first swells, then becomes of a grayish color with punctured spots in its substance, the arteries at the same time becoming thready; still later the disc appears as a bluish-white spot, completely devoid of blood vessels, excepting one or two small twigs which may be discerned running over its edge.

In the other form, where the vitreous is so cloudy it veils the fundus completely, the opacity is due to the products of inflammation transudation, which, if properly treated, will be more or less absorbed, and then we may find changes similar to those described above. Although retinal hemorrhages are rare in syphilitic retinitis, yet they sometimes occur, as proven by a case of retinitis following syphilitic iritis that we have lately had under obser-

vation, where several large diffuse, and some small circumscribed hemorrhages were seen at the outer side of the periphery of the retina of one eye, over eight weeks after both vitreous bodies had been so clouded by exudation that neither disc could be seen, and nearly thirteen weeks after a violent iritis in both.

In treating syphilitic retinitis, we are powerless without mercury, which may be administered hypodermically, as the bi-chloride, one-sixteenth to one-fourteenth grain daily, or in pill form, as the biniodide, one-tenth grain three times a day, accompanied by inunctions of mercurial ointment night and morning; subsequently, we can use Zittmann's decoction, or the iodide or bromide of potassium, with tonics. The above mentioned remedies are useless, even injurious, unless the patient remains in a dark room, well clothed, and in bed most of the time, observing regular but not strict dietetic rules. Bodily as well as mental rest, we will again mention, as one of the most important and absolute elements in treatment.

Retinitis Potatorum.

One other form of inflammation of the retina is known as retinitis potatorum, and is induced by the abuse of alcohol, tobacco, etc. The following case, one of a number which have been treated by a new remedy, with observations, will, I trust, be found interesting as well as instructive. The action of alcohol, in whatever form, is, first, to lessen the action of the skin, and second, to divert the blood from the circumference toward the central organs. The pulse becomes fuller and harder, producing congestion of the liver, heart, brain, and consequently the eyes. The tendency of both these effects is to increase the vital processes, hence alcohol is of the greatest service when the body is feeble and exhausted, or injurious when the persons are young, of sound health, or plethoric habit. The tendency to congestion of the blood centres is shown by the post-mortem conditions of such internal organs, and by the fullness of the vessels of the head, eyes and face. Beer and wine are food, because they contain nutritive elements other than alcohol, but it has been shown that the latter is not transformed in the system, and does not enter into new combinations, but leaves the body almost unchanged.

It has been proven, by Dr. Percy, Edwin Smith, and others, that after alcohol has been given to rabbits, it was found unchanged in the brain and other internal organs, twenty-four and even thirty-six hours afterward, a fact opposed to the idea of change.

MM. Lallemand and Perrin, instituted special experiments from which they showed that after alcohol had been administered, it passed off by every outlet of the body for many hours, giving the reaction of alcohol. These experiments we have repeated, and have witnessed them in numerous instances. The action of alcohol is chiefly upon the sympathetic, and lessens its influence, while at the same time, in my own person, it always produces irritability, and unsteadiness in the action of the heart. Dr. B. W. Richardson, of London, from experiments and observation, has compared it to chloroform, only that alcohol is less fatal. It kills, however, large numbers of persons in England, and in this country the average number is about fifty thousand annually. Its method is very slow, indirect, and generally by painful diseases. As we have before stated, alcohol, when taken into the animal body, reduces the temperature, so that cold and alcohol, in their effects on the body, are closely allied. The experience of our Arctic voyagers, of the leaders of the great campaign in Russia, of the good monks of St. Bernard, and in our own army, proves that death from cold is accelerated by its ally, alcohol.

Alcohol becomes, therefore, a dangerous instrument in the hands of the wise and strong, and a murderous instrument in the hands of the foolish and weak. Used too frequently, used too excessively, the agent that in moderation cheers the failing body, relaxes its parts too extremely, spoils vital organs, makes the course of the circulation slow, imperfect, and irregular; suggests the call for more stimulation; tempts to the renewal of the evil, and ruins the mechanism of the healthy animal before its hour for ruin by natural decay (see Dr. B. W. Richardson, E. Smith). By its influence these organs are undergoing physical changes tending to the destruction of their functions, and to perversion of their structure. Thus the origin of alcoholic phthisis, of cirrhosis of the liver, of degeneration of the kidney and heart, of diseases of the membranes of the brain and spinal cord, and various modifications of organic portions of the eye, so often observed by the pathologist. Alcohol in its effects upon the eye and vision, we know has not received the attention which

its importance and frequency demands. In our clinic we frequently find cases where the eyes have become so thoroughly disorganized and diseased, that blindness is the inevitable result, while the number of those who suffer from more or less imperfect vision are very numerous. It occurs not only among the poor and illiterate, but frequently, to our sorrow, also among the refined, educated and wealthy.

As I have already stated, it assumes the form known as *amblyopia potatorum*. Our prognosis is good in this disease if the alcoholism has not progressed too far. Alcoholic amblyopia does not necessarily lead to atrophy of the optic nerve, but if neglected and the habit of drinking is persisted in, it will in time surely lead to total atrophy, nay, incurable blindness. In the latter stage of this affection benefit is sometimes afforded by hypodermic injections of one of the salts of strychnia.

N. W., aged 30, physician, was suddenly surprised, one morning in March, 1873, with almost entire loss of vision of right eye. When he came to see the writer there was a constant circle, of brown color by day, around the field of vision. At night this brown changed to red, and then to a bluish cast over any object whenever he attempted to use his eye. He has had but little pain; right eye slightly softer than the left; general health has been good, with the exception of some disease of the liver, with jaundice, for which he took a trip to Europe, etc., and since his return has been well, looks robust, ruddy and stout, but is much depressed with the lost or obstructed vision. He is married, and never had any severe sickness, but lost his father and an uncle with apoplexy. On inquiring into his habits, found he used both brandy and whiskey freely, the latter excessively, ten to twelve drinks each day, besides half a pint at bedtime; so, averageing these drinks at two ounces, he must take at least two pints and a quarter in the twenty-four hours; yet this he stated did not intoxicate him, but he could not sleep without his nightly potion. Eye looked normal, no injection of conjunctiva or sclerotic, good action of pupil, and no opacity of crystalline lens.

The examination with the ophthalmoscope revealed intense congestion of the retina, with effusion around the rim of the disc. Ordered him to give up his stimulants at once. To take ten grains of iodide of potassium three times a day, which was soon replaced by the bromide in increasing doses, from its known influence on the brain and nervous system, with absolute rest for the eyes.

March 14th. Patient has followed out directions to the letter. Arteries of retina not as full, but veins still too large, with here and there small deposits of pigment in the vitreous. The field of vision much clearer, no brown color now seen, only blue, and patient is very nervous.

April 29th. Vision so much improved that he can read without difficulty at ordinary distance. Reads No. III (Snellen). Ophthalmoscopic examination. A slight film is seen over retina and edge of disc, with hazy aspect.

May 11th. Treatment continued. Eye almost well; disc clear, and blue color gone, but suffers from bodily weakness; ordered one-sixtieth grain strychnine daily, to be gradually increased to one-thirtieth; this was to relieve the desire for stimulant.

October, 1873, met my patient in the street; says he is well, but if he indulges the least, has a return. He states that after attending a fatiguing confinement took about two ounces of gin, and in the morning had a slight return of his obstructed vision, which fortunately cleared away in a few days, by the use of the bromide, with rest and abstinence.

This interesting case was seen and examined by several ophthalmic surgeons of this city and New York.

I find within this month, November, 1874, a notice of the same agent, the bromide, being used by an Italian ophthalmic surgeon, with good success, but I consider I have the credit of employing the agent one year before Dr. Quaglino. The following are his remarks on the treatment:—

Dr. Quaglino (*Annale de Ottalmologia*, vol. iii, and *Gazzetta Medica Italiana-Lombardia*, March, 27th 1874) regards alcoholic amblyopia as a result of the abuse of alcoholic liquors. "Taking into consideration the sedative action of bromide of potassium on the nervous centres of reflex action, and its effect in reducing the action of the heart and lowering the temperature, and bearing in mind the contraction of the retinal vessels observed by Lewizki to follow its use, Dr. Quaglino determined to try the effect of this drug in gradually increasing doses. He began by giving fifteen grains in one hundred and seventy pints of water, and increased the dose gradually till toxic effects

began to appear. He relates seven cases thus treated; in some the cure was complete, in others the disorder was arrested, and in none was there a relapse."—*London Medical Record, May 27th*, 1874.

The writer cannot but desire to impress upon the hard working physician, not to neglect the use of the microscope and ophthalmoscope in deep-seated diseases of the eye and all obscure disorders of the brain and kidneys; for the neglect to use all these aids to form a correct diagnosis, he is culpable, and has not done justice to the life placed in his hands. The case about to be reported is an instance of such neglect; one of many which has come under the writer's notice during the last twenty-nine years.

Retinitis Albuminurica.

Was called June 14th, 1872, to visit Charles McG., age thirty-three, engineer, Philadelphia; born in Ireland, of healthy parents, both of whom are living; never was sick; sober; would only take his beer on Saturday night, never through the week. Had charge of an engine on Cherry street, in a double cellar; it was very damp, no ventilation except one place, where there was a draft, and he frequently had to ascend to this spot to cool his heated body; has been on duty for twelve months; four months ago he contracted, as he supposed, a cold, from this exposure, and he had a cough, which in spite of ordinary remedies was not relieved; he had also a constant pain in the centre of his chest, as if there was a swelling.

He has been under the care of a surgeon for two months, who he states benefited him slightly at first, but latterly he has been getting worse, so that the writer was sent for; he has now a constant pain over his left kidney, with entire loss of vision of his left eye, which he states only occurred six days ago; after a change of his medicine by his former physician. He returned home and went to bed, taking a dose of it (a mixture of quiniæ sulph., tinct. ferri sesquichloridi, etc.), and in the morning he found he was blind in the eye; he desired his mother to look at it, and the only change she noticed was that it was smaller. Has lost forty pounds; formerly weighed one hundred and sixty-seven pounds, now one hundred and twenty-seven pounds.

The writer made an examination, and found skin pale, slightly yellow, wax like color; eyes languid, and eyelids puffy; slight strabismus of left eye; has had a slight moving body, at times, pass in front of the right one. The temperature of skin lower than normal; feet and limbs dropsical; pitting on pressure; tongue slightly furred; pulse 108.

Examination of Chest.—Mitral disease of heart, with regurgitation; area of dullness in cardiac region four by six; loudest sound over sternum (aortic valves affected); dullness over posterior portion of lungs, both sides, but not marked. Respiration slow and labored.

Examination of Urine.—Of a slight brownish color, with delicate flocculi in it; by heat alone one half albumen was thrown down, separated, but not dissolved by nitric acid, and became brown.

Ophthalmoscopic Examination.—Left optic papillæ covered with patches of white atrophy, with retinal apoplexies visible all over. Right eye a definite cloud, with congestion.

June 17th, 1872. Examination of urine by Prof. James A. Meigs, with microscope, revealed hyaline casts.

This patient stated to the writer that his urine had never been examined until the present time, and no ophthalmoscopic examination of his eye had ever taken place. The friends of the patient were informed of the unfavorable character of the disease, but still clung to hope, and employed a physician who gave a more encouraging prognosis, but we were informed that dropsy gradually supervened, and he died in the course of two weeks from the time of our visit.

DISEASES OF CHILDREN.

BY DR. A. B. TADLOCK,
Of Knoxville, Tenn.

Notwithstanding the vulnerable condition of children under the age of five to contagious and many unavoidable diseases to which the grown, for various reasons, are less disposed, we venture to defend developmental life, and challenge errors of hygiene, maltreatment and parental neglect, to answer for the unnatural infant mortality, as is shown in all mortuary reports. If physical perturbations and aberrations do follow and belong to the evolutions of development and growth, the compensating vis conservatrix presides over the natural processes with conservative authority.

We propose, then, to examine some of the physiological and hygienic conditions which render the young peculiarly susceptible to certain diseases. Studying our subject, we una-

voidably observe a natural duality of conditions which dispose tender age to diseased action, the subjective and the objective. The first, and by no means least common conditions are incident to development–perverted nutrition and hygienic influences. The second are accidental and independent of the first, and offer infectious and contagious distempers. To make the contrast plainer and more definite, we would class, for example, the conditions giving rise to irritation and diarrhœa, with, sometimes, very ugly nervous phenomena, incident to teething, as subjective. the derangements following or falling in as the result of development. Then the objective would embrace those conditions by which the disease, measles, for example, accidentally, and generally at a very early age, is wont to follow or fall upon the child, as the result merely of former escape and its constitutional receptivity.

On account of this receptivity growing out of the objective condition and former escape, one, without the counteracting influence of vaccination, takes small-pox when exposed to its peculiar infection. Measles and mumps likewise attack subjects possessing the objective nature, as the only suitable ones for successful conquests. Subjectively the system tolerates many complaints besides developmental bearings, colds, pneumonia, etc. Truly there is a *vis viæ aut vis animæ* which appears to modify and sometimes defy diseased action, whether objectively or subjectively induced or invited.

The degree of prohibitive force is not only unequal in different individuals, but in the same individual at different times.

Case 1.—A physician was professionally exposed in the treatment of small-pox patients, in Nashville, in the spring and summer of 1862, without contracting the disease, but in Feb., 1863, in Cincinnati, easily yielded to its influence upon a single visit to a patient, not being in his presence more than half a minute. This case bore a good cicatrix of early vaccination, and had been again successfully revaccinated in the early part of 1862, yet he had a very severe case of varioloid, more or less confluent, leaving marks visible on the face and back for two or three years afterwards. Nature, we see, essays sometimes to effectually overcome even the objective disposition, and no doubt, under favorable and attainable influences, hygienic and physiological, she would be sufficient in the majority of cases to regulate the constitutional tolerance of all diseases. So that death in old age would be the rule, and in infancy the exception. Developmental complaints would be regarded wholly as health preserving agents, and others subjectively considered would almost if not entirely disappear from our nosological vocabulary. The value of preventive medicine and the object of medication and treatment in this light become more clearly defined; cherish and try to secure the favorable and attainable influences, discarding the empirical notions that medicine is everything, and that nature, God, and the universe are nil.

The etiology of croup and whooping-cough is not satisfactorily understood, and though the latter seems to be infectious, and makes but a single attack upon the same individual, they both belong to childhood almost exclusively, the former after the first year, the latter after the cerebro-physical relations are established more perfectly; hence we believe these to be of developmental origin, whose objective features are wholly secondary and entirely due to subjective evolutions. In reference to this idea of whooping-cough having a cerebro-physical relationship with spinal complications we copy

Case 2.–A colored girl, eight years old; "been treated three or four months, by two or three doctors, for whooping-cough, but nothing did her any good, and she was getting worse all the time," were the words of the anxious mother, as she entered my office to seek further advice. Her cough was almost identically that of whooping-cough, only the spasms were more frequent, without any intermission of the dyspnœa. Upon examination, I discovered a slight protuberation of the second dorsal vertebra. In two or three days the child died, and post-mortem revealed a total destruction by caries of the body of said vertebra, with a partial loss from each of the adjacent ones. By continuity of parts the inferior cervical ganglia, which communicates directly with the pneumogastric, became affected, and thence by the recurrent laryngeal and other connecting branches produced the spasmodic whooping characteristic of the pathology. But it is not our purpose here to argue the pathology of croup and whooping-cough, only to suggest that their constitutional tolerance is subjective, and consequent to development, with natural life forces designed to regulate that tolerance to the safety and perpetuity of every human being, otherwise life would be the sport of nature and the creation.

If the vital activity of the nervo-vascular and musculo-nutritive powers do predispose the young to accidental and incidental maladies, they likewise furnish relative eliminating and prophylactic forces, without which the perils of primitive life would put beyond question the mortal conquest at a much earlier age in our struggle for existence: Wherever, in the cycles of biology, nature ordains weakness she likewise orders compensatory strength. If developmental processes, as in dentition, institute derangement, nature follows quickly with healing in her wings. "Death in childhood is an unnatural event." Nature essays to perfect every creation, evolution and development, from the planting of the embryonic germ-cell to the full man in his prime and in his declining years. Were it not so, the contingency of human existence would seem quite problematical. With equal hygienic advantages and competent parental care, we doubt if the developmental period under five years of age should be the most hazardous of human life. Why, then, all this infant mortality? Why so little concern for a subject of so great interest and importance to parents and peoples? In the face of figures and facts, instead of the constant drifting of population to urban homes, would it not be more natural for parents to flee with their little ones to the mountains?

Editorial Department.

Periscope.

Some Neuroses of the Larynx.

Dr. James Sawyer, physician to the Queen's Hospital and to the Children's Hospital, Birmingham, writes to the *British Medical Journal*:

If we exclude laryngismus stridulus, a disease which I do not propose in any way to consider, by far the commonest nervous affection of the motor system of the larynx is that which Dr. Mackenzie has called "bilateral paralysis of the adductors of the vocal cords," and which has been long known, or at all events probably designated, by a variety of names, to wit, functional aphonia, hysterical, aphonia, paralysis glottidis, etc. Of the sufferers from this disorder, a very large majority are hysterical women. I use the phrase, "hysterical" in its ordinary and well known acceptation. In this form of aphonia, I believe that there exists in most cases, perhaps in all, some definite pathological change in the larynx, such as congestion or chronic inflammation of the mucous membrane, of very moderate intensity, and that the phenomena arising from this trivial local lesion become, under the influence of the hysterical condition, whatever that may be, exaggerated, distorted, transformed, and multiplied. The muscles at fault are the two crico-arytænoidei laterales and the arytænoideus proprius, those muscles which approximate the vocal cords and the arytenoid cartilages. These muscles fail to sufficiently respond to *ordinary* efforts of the will. The subjects of this disorder are generally young, nervous, weakly women. They cannot speak above a feeble whisper; and this condition often lasts for years. It sometimes comes on quite suddenly; it frequently dates from the hoarseness of an ordinary cold, the impairment of the voice remaining and increasing after the original catarrh appears to have passed away. When we examine with the laryngoscope, and direct the patient to say "Ah," we can see that the vocal cords, lying widely apart, either do not move at all, or move only to a slight extent during the attempt at vocalization. We usually see no other morbid condition beyond, in some cases, a little pallor of the mucous membrane; in others, slight hyperæmia. The reflex movements of the cords are generally unimpaired; during coughing, the cords may be often observed to move freely. Laughing is sometimes ludicrously noiseless. I must not omit to draw attention to a very curious symptom which is frequently met with in these cases; viz., anæsthesia of the epiglottis. We may pass an index-finger over the patient's tongue and tickle her epiglottis, vigorously and for some moments, without causing spasm, choking, or any uneasiness whatever. I have demonstrated this condition over and over again. This strange symptom was pointed out some time ago in one of the medical journals, but I regret I am unable to refer to the article. I am quite sure that, in many of these cases, a blunted sensibility of the mucous membrane of the throat extends far beyond the epiglottis, and involves more especially the pharynx and palate. Any one who has had much practice in laryngoscopy knows how well these throats tolerate the laryngeal mirror; a beginner with the laryngoscope can have no better subject to practice upon than a good-natured woman with functional aphonia. Limited anæsthesia in other localities has long been known as an occasional manifestation in hysteria.

The prognosis in these cases of voicelessness

is nearly always favorable; we may usually confidently predict a cure.

In treating such a case, we ought to aim at improving the general health as much as possible. Any hyperæmic or inflammatory condition of the laryngeal mucous membrane ought at once to be remedied. I know nothing better for this purpose than the frequent application of a solution of nitrate of silver to the interior of the larynx. This stimulates the parts, and so favors the nutrition of the affected muscles, which may have become seriously deteriorated by prolonged inactivity. These measures alone suffice in many cases; when they do not, in local faradization we possess a very effective remedy. For its application, I can confidently recommend Mackenzie's apparatus. One pole should be applied to the neck, over the thyroid cartilage, and the other, with the aid of the laryngeal mirror, to the vocal cords. Complete restoration of the voice and complete control over the adductors of the cords is often the instant and lasting result. Mr. Durham relates a case in which the introduction of the throat-mirror alone was attended by immediate recovery from aphonia. In many instances, the voice is only gradually regained under the frequent and long-continued use of faradization. How the remedy acts in these cases I cannot say; I can only repeat what I wrote on this subject some time ago; viz., that, in faradization in this kind of aphonia, we probably frequently have nothing more than a convenient agent for "filliping" the dormant muscles and defective will into normal relationship. I cannot too strongly urge the importance of a due attention to what may be called the psychical elements of treatment. The medical attendant ought to cheer his patient with the confident prediction of a speedy recovery; he ought to secure her cordial co operation in the measure he advises, and encourage her to make every effort to regain control over the affected parts. I have spoken of these patients as women; but one of the most marked cases of this affection I have ever seen was that of a stalwart, healthy-looking man.

Foreign Body in the Œsophagus.

The Paris correspondent of the *British Medical Journal* says:—

At the Surgical Society, M. Duplay communicated the case of a man, aged 62, who had been a patient in the Hôpital St. Antoine. He stated that, the day before his admission into hospital, on September 25th, the man had swallowed a small piece of bone with his soup, which was evidently stopped in its passage in the œsophagus, as he complained of severe though ill-defined pains behind the sternum. The house-surgeon introduced a probang, which was stopped by an obstacle about nineteen *centimètres* (about seven inches and a half), measuring from the middle incisors of the upper jaw; but, with a little manœuvring of the instrument, he passed the obstacle, and was in hopes that, in withdrawing the probang, the obstacle would be removed. In this, however, he was disappointed, and M. Duplay then introduced on the following day the tube of a stomach-pump, but not with more success than his assistant; the instrument passed the obstacle, but brought nothing with it on being withdrawn. M. Duplay then introduced another tube with an olive-shaped extremity, which passed easily into the stomach; the patient could swallow easily both solids and liquids, but the obstacle was still in the gullet, as he continued to feel the pain complained of at the commencement. M. Duplay, however, was disposed to believe that the bone had been removed by an emetic the patient had taken the day previous to his admission. On September 28th, symptoms of dysphagia set in, which was attributed to spasmodic contraction of the œsophagus, and, on the 30th, the patient died with symptoms of broncho-pneumonia, complicated with pleuritis. At the necropsy these symptoms were verified by the lesions found in the lungs, which were also highly congested. At five *centimètres* (two inches) from the superior extremity of the œsophagus, a fragment of bone of a triangular shape was found lodged in it: it had perforated the organ at a level with the fourth dorsal vertebra and almost in immediate contact with the arch of the aorta, from which it was separated by only one *centimètre* of cellular tissue. This interesting case gave rise to a warm discussion as to the proper measures that should have been employed, and it was decided that œsophagotomy offered the only chance of saving the man's life. M. Trélat, however, was of opinion that, before resorting to such a serious operation, especially in the absence of rational and physical signs, explorations ought to be made with a sound of sufficient calibre to completely fill the œsophagus, as with a smaller instrument one is likely to pass over the obstacle, as in the case under notice. Moreover, a stouter instrument would be useful in overcoming the spasmodic contractions of the œsophagus caused by the presence of the foreign body, which, under such circumstances, is generally found imprisoned in the organ, which, sooner or later, becomes ulcerated or perforated. It is, therefore, of the utmost importance that a proper diagnosis be made as early as possible, in order that decisive measures, as œsophagotomy, may be resorted to at once, after having given all other means a fair trial.

On Examination of the Heart.

Dr. G. W. Balfour, in the Edinburgh *Medical Journal*, remarks:—

From the formation and position of the heart, it is obvious that, though we can and may percuss out the whole of the cardiac dullness, this is quite unnecessary; it is only of importance to ascertain its greatest extent of dullness vertically and transversely. Increase of the vertical dullness rarely indicates any alteration in the size of the heart itself, but is usually either due to hepatic enlargement, readily ascertained by

an extension of these exploratory methods to the liver itself, or to pericardiac effusion—the former dullness, as a rule, extending below the sixth rib, the latter above the third; while a simple change of position of the heart, which may arise from various causes, is indicated by a transference of the normal dullness upward or downward, without any change in its extent. The apex-beat, except in certain abnormal conditions, is, from the formation of the heart, the part which extends furthest to the left, and being, as a rule, perceptible to the touch, only requires to be percussed out in those exceptional circumstances where the true apex beats beneath a rib, and not in an interspace. The right auricle is, of course, that part of the heart which extends furthest to the right, and being extremely dilatable, and readily influenced by any obstacles to the onward flow of the blood, transverse dullness about the level of the fourth rib comes to be an important indication of some obstacle to that onward flow, and therefore of enlargement of the heart chiefly in its auricular region. These, therefore, are the chief points in regard to which we look for important information from the percussion of the cardiac dullness. Increase of dullness above the third rib indicates, as a rule, pericardiac effusion. Increase of the transverse dullness at the level of the fourth rib indicates obstruction to the circulation. If the apex-beat be displaced to the left and downward, the obstruction is probably aortic, and has primarily influenced the left ventricle; if the apex-beat be not displaced downward, the obstruction is either mitral or pulmonary in its origin.

The Use of the Tow Pessary.

Dr. Martin says, in the British *Medical Journal*:—

In August, 1873, Mrs. A. requested me to attend her. She complained at that time of great pain across her loins and a bearing down of the womb. Upon inquiry, she informed me that she had had a family; that her last confinement was a tedious one, requiring the use of instruments; and that all her former cases had been good ones, requiring but little attention from her medical attendant. Upon examination, I found the uterus a little extruded, being easily returned, but at once extruded after the removal of the fingers from the vagina. I advised her to rest in bed or upon her couch for the time being. On the morrow I called to see her again, and for the want of a proper pessary, I placed a quantity of tow, covered with a piece of well-greased lint, within the vagina, having previously returned the uterus to its proper position. I called again the third day, and found my patient much better, almost free from pain, and no extrusion of the uterus. I removed the pessary, and replaced it by a fresh one made in the same way as the first. After the lapse of three or four days, I again removed the tow, replacing it this time by a mass shaped after the manner of the oval boxwood pessary, covered with gutta percha tissue in place of the lint. This I allowed to remain for four or five days, requesting my patient to try to remove it herself if it should cause any pain. During the time she was wearing the pessary, I advised her to walk as little as possible, and to rest upon her couch most of the day. To regulate the bowels, I gave one or two compound rhubarb pills at bedtime occasionally, and as a tonic, a little quinine and iron three or four times daily. I continued this treatment for a few weeks, to the great relief of my patient. She now goes about her duties as a housewife with ease, at times only feeling a little pain across her back, but no sign of any prolapse. Should a similar case come under my care, I shall adopt the same plan of treatment.

On the Local Use of Tannin.

Mr. Thomas writes to the *British Medical Journal*, on concentrated solution of tannin as a styptic. I have used it for some years, as a topical application, in various diseases, though rather as an astringent than a styptic. To prepare it of full strength, an ounce of perfectly fresh tannin must be mixed with six drachms of water, in which it readily dissolves. The solution is a thick fluid, of the color and consistence of treacle, which keeps much better than tannin itself.

Most of the tannic acid found in shops contains a large proportion of gallic acid, and will not yield a very strong solution. But, if an ounce of old tannic acid be mixed with two ounces of water, a tolerably strong solution, which answers for many purposes, may be decanted off after subsidence.

The strong solution of tannin is a most powerful astringent, almost free from irritating properties. It is one of the best dressings for wounds, far superior to collodion, and even less irritating than the styptic colloid, which it somewhat resembles. If applied by a brush and allowed to dry, it soon forms a pellicle which excludes the air, and gives ease to pain. It may be applied to almost any form of ulcer, and to wounds after amputations or other operations, especially when not very deep. It answers well, for instance, after the operation for hare-lip, painted over the pins and threads, in the same way as collodion is sometimes used.

In a female, aged twenty-six, the hair was caught between rollers and the whole scalp removed to within an inch of the left eyebrow, and two inches from the right, round on a level with the tips of the ears to about the external occipital protuberance, the periosteum being extensively removed at the vertex. There was much suppuration, followed by erysipelas. After three months, exfoliation of bone occurred, and skin-grafting was performed, first with eleven grafts, and, six weeks subsequently, with twenty-one. After varied treatment, antiseptic and other, little progress was made, till, nine months after the accident, strong tannin solution was applied. Discharge and fœtor dimin-

ished at once, and the healing process went on more quickly than before. Tenderness diminished, and the general health improved rapidly for the first time since the accident. The wound, eighteen months after the accident, was about half its original size, and the discharge trifling. The patient does household work, wears only a thin cap, and is little worse for the accident, generally or locally.

Strong tannin solution applied to the ulcerated skin of ingrowing toe-nail at once removes pain. After one application, the offending corner of the nail may be readily raised, a little lint inserted underneath, and the nail allowed to grow up. Among many cases, I have in this way cured one in which evulsion, twice performed, had proved only a temporary remedy, the disease being reproduced each time the nail grew up. For cracked nipples, this solution, diluted with an equal quantity of water, is the best application, and corresponds to the tannin solution commonly used for this purpose.

Enlarged tonsils may be reduced by daily brushing with this solution. This treatment, though vastly inferior to extirpation, or even to the application of potassa cum calce, is painless, and therefore, in some cases, useful.

Bleeding warts may be readily removed by this application, as also by the perchloride of iron. I have found the former to readily reduce the granulations from an unhealed umbilicus in an infant.

Skin Eruption in a Child, Caused by Bromide of Potassium Taken by the Mother.

Dr. Tilbury Fox reports this case in the *Lancet*:—The following case illustrates a fact that has not, as far as we know, been hitherto recorded. As is well known, bromide of potassium sometimes produces an acne-like eruption on the skin of the person to whom it has been administered; but it has not, we believe, been known to cause such an eruption on a child suckled by a person who is under its influence.

E. W——, aged three months, born on December 1st, was sent to the out-patient department of University College Hospital on Saturday, March 14th, by Dr. Glover, with a curious eruption, which at first sight seemed to be a probable result of vaccination. The child was vaccinated on February 10th, and the vaccinia ran its usual course in six places locally. About six days afterwards, the child being perfectly well at the time, there appeared about the cheeks a few pimples, which soon ran one into another. Then more spots came on the arm; and one of the vaccination marks became red and inflamed, and rose up into a little pustule, and finally covered the whole scar. Pimples then came upon the legs and buttocks, and have gradually increased to the present time. When the child was first seen at the hospital it presented the following appearance:—It was well-nourished, plump, and by no means cachectic; and it did not look ill. Its complexion was somewhat dull-looking, and the child had a semi-bronzed appearance about the face. At the seat of vaccination were recent scars, of usual aspect, except in one spot, which was prominent, the size of a split-pea, and had an indurated inflammatory base and a flattened top, presenting the appearance of a pustule just beginning to dry up. On close inspection it seemed as though a milky fluid was contained, at least as a superficial layer, beneath the upraised cuticle. A similar spot was observed under the chin, and a third on the forehead; on the right cheek were several acne-like places, and on the left cheek were four or five reddened patches, one the size and shape of half an almond, two lines or so in elevation; a second the size and shape of a fourpenny-piece, and two others much smaller. The patches were of a dullish-red hue, and on close examination were seen to be studded over with minute openings beneath a superficial layer of cuticle. These openings were the mouths of the hair-follicles of the skin. The patches were seen to be made up of a congeries of congested and closely packed sebaceous glands, from which had escaped a certain amount of sebum, which still formed the superficial layer. It was this appearance that gave the clue to the eruption. In some parts of the patches there was a speckled appearance, produced by the escape of milky-looking sebum, and by its confinement beneath the scales on the surface of the patches. The patches were not painful. On the left arm were some very large acne spots dying away. On the buttocks were about a dozen large spots of well marked pustular acne, in various stages; there were a few similar spots on the back of the legs. The hands and feet were free from all trace of the disease. The anus was healthy. There were no moist tubercles about the mouth or elsewhere, and no other signs of constitutional syphilis. On inquiry, the mother stated that the patches on the face developed out of the acne-like spots by the crowding together of a number of them.

Abnormalities of the Pulse.

Dr. George Balfour, in a clincial lecture on diseases of the heart, in the *Edinburgh Medical Journal*, says:—

"In further examining the condition of our patient, we first feel both radial pulses simultaneously, noting whether the arteries are firmer or more tortuous than usual (atheroma). If there be a marked difference between the two radial arteries, we feel both brachials simultaneously; if these be equal, the difference between the two radial arteries is due to irregular distribution. If the brachials differ, in all probability there is some abnormal physical cause to account for it, possibly an aneurism. Should the radial pulses be equal and regular, but small and feeble, we elevate the wrist to a level with the head, if the patient be sitting or standing; if lying, we elevate the arm to its full length perpendicularly to the body. Should the pulse then become extinguished, or nearly so, the patient is anæmic, and possibly anæmia

is his sole disease; but we must never, under any circumstances, rely on one symptom, however apparently trustworthy, but merely note it as an aid and a guide in our further investigation. Should the pulse, after elevation of the arm, remain still small and feeble, but distinct, the cardiac disease, if present, is mitral. Irregularity of the pulse confirms this suspicion; extreme irregularity points to the probability of the affection of the mitral valve being constriction rather than dilatation. Should the small, feeble, and possibly irregular pulse remain not only distinct after the elevation of the arm, but become more so, the systolic impulse being followed by such a sudden and complete collapse as to render the impulse apparently more marked, then we have to do with a double lesion, a mitral and also an aortic regurgitation. This form of pulse is, however, not always well marked, in many cases is not easy of detection, and is therefore not to be relied upon, unless the collapse is distinct. In simple aortic regurgitation, however, the peculiar sensation conveyed to the finger, and well-known by the terms hammer, or Corrigan's pulse, is usually well-marked, and frequently so greatly increased by elevation of the arm as to become almost painful, and wholly unmistakable."

Algidity in Strangulated Hernia.

At a recent meeting of the Société de Chirurgie, says the *Times and Gazette*, M. Demarquay brought under notice the algidity observed in the subjects of strangulated hernia, his attention having been originally drawn to the subject by having had brought into the Maison de Santé a man who was supposed to be dying of cholera, which was then prevailing epidemically. He was vomiting, and in a state of almost complete cyanosis. M. Demarquay, observing that the vomits were not choleraic, but stercoral, rightly diagnosed strangulated hernia, as the event proved. Observing so considerable a depression of the general temperature in this case, he investigated the condition of the temperature in other cases, and found that it was sometimes increased and sometimes diminished. This difference he felt disposed to attribute to the difference in the seat of the strangulation, having observed that the greatest depression of temperature took place when the strangulation occupied the upper portions of the small intestine, this being probably due to the abundance of the nervous supply for these parts. He instituted experiments on dogs, producing constriction at different heights of the small intestine; and he found, in proportion as this influenced the parts nearer the duodenum, the consequent depression became more or less considerable. He therefore believes that the modification of temperature observed in these cases depends more on the seat of strangulation than on any other cause.

M. Verneuil observed that he had engaged in this investigation since M. Demarquay had done so, but had not arrived at quite the same conclusions. At his request, M. Terrilon, one of the ablest of the anatomical demonstrators, submitted the intestines of seven or eight dogs to very firm constriction without observing any depression of temperature. So, too, with regard to the influence of the seat of the stricture, M. Demarquay's remarks are not secure from criticism. Last year a patient was brought into Lariboisière complaining of fearful abdominal pains, there being vomiting without stools, while the abdomen was absolutely depressed. The temperature was only some tenths above 32° C. (95° F.), the algidity being such as is met with after very abundant hemorrhage or the most violent traumatism. From the sole fact of the great depression of temperature, M. Verneuil did not hesitate to diagnosticate a hyperacute strangulation of the intestine. The patient having rapidly sank, it was found at the autopsy that there was a strangulation occupying at least twenty-five centimetres of the large intestine, the sigmoid flexure being in a livid state. So marked was the strangulation that it might have been supposed to be produced by a tightly tied ligature. M. Verneuil is of opinion that the sole fact of a notable depression of temperature is in certain cases a precious means of diagnosis, enabling us to distinguish with certainty strangulated hernia from simple intestinal obstruction; but it is evident that at present we are ignorant of the laws which regulate these modifications of temperature.

Reviews and Book Notices.

BOOK NOTICES.

Proceedings of the Medical Association of the State of Arkansas. Fifth Annual Session. Little Rock, 1874. pp. 43.

This rather slim pamphlet is made up of the minutes of the meeting, the address of the President, Dr. E. R. Duval, of Fort Smith, who touches on medical legislation, criminal abortion, and medical education; a case of compound fracture of the femur, tibia, and fibula, described by Dr. J. A. Dibbrell, Jr., of Little Rock (also in this journal, Aug. 15th, 1874); a case of encephaloid cancer of the bowels, by the President; an instance of complicated epilepsy, by Dr. J. E. Bennett; one of cerebro-spinal fever, also by the President; molar pregnancy, by Dr. Alfred Dunlap; complicated fracture of the humerus, by the same; and a remarkable case of elephantiasis, described by the President, to which we referred on a previous occasion.

MEDICAL AND SURGICAL REPORTER.

PHILADELPHIA, DEC. 19, 1874.

D. G. BRINTON, M.D., Editor.

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CONSIDERATIONS ON CLIMATES.

Year by year the mass of physicians are becoming more and more convinced that the generally unsatisfactory condition of therapeutics is owing, more than to any other one cause, to the unfavorable surroundings of patients. What good can we expect drugs to do in a case of cholera infantum in a foul city slum, with the thermometer at 90°, with thin milk from diseased distillery cows as the infant's food, and when half a dozen other children are crammed into the family's one room? Yet this is a scene which every physician witnesses daily, in this city, in July.

As a fashionable New York practitioner once remarked to us, there is no satisfaction in attending poor patients; not only is the pay insignificant, but one becomes disheartened with one's ill-success. The rich can summon to their aid the accessories of hygiene, and this gives them an immense advantage in the struggle for life, and throws much also in favor of the proper action of drugs.

One of the most important of these accessories is climate; and in spite of the fact that it has received so much attention, it remains a matter of difficulty to advise upon it knowingly. Tens of thousands of persons migrate every year from this city, alone, either to seek warmer winters or cooler summers. The question they all ask their physician is, whither shall we go? He generally answers at a venture, and gets the credit of a chance success.

Now, without attempting to enter at all thoroughly into this vast subject, we shall state a few characteristics of the climates most suitable for invalids, the feeble, or the aged. There are, indeed, some diseases to which these general remarks will not apply, but we have in view the majority.

The first element of health in a climate is *dryness*. Intense heat and intense cold can be borne easily if there is little moisture in the atmosphere. In some Turkish baths—that in Jermyn street, London, for example — the

hot-air chamber is 232° Fah., twenty degrees hotter than boiling water, yet one can support this temperature for many minutes, on account of the dryness of the air. In the Colorado and Arizona valleys, many summer noons register 110° to 120° Fah.; but for the same reason the heat is not debilitating, and sunstroke is unknown.

On the other hand, a damp cold air is notoriously apt to produce catarrhs and other bronchial affections. It has been statistically proven that the damp east winds increase functional disorders of the liver, and thus depress the spirits and render the temper more irritable. The exhaustion felt in the moist warm days of August is well known. A marked disinclination to exercise when the air is nearly saturated is noticed in every gymnastic class.

The next important feature is a *limited range.* This is far more important than the actual temperature itself. Indeed, a careful study of the subject will convince any one that the temperature, providing that it is not a very unusual one, is of very little moment. Providing that it is not very variable, not subject to rapid fluctuations, it matters little whether it be low or high.

To be more definite, we mean by a limited range, one within 20° in the twenty-four hours, and never greater. This is liberal enough. At Callao the annual range is 12°; at Santa Cruz the diurnal range about 8°; at Miami river, Fla., the annual range is about 40°.

These are the two leading features of a model climate; and it is annoying to consider that very many thermometrical records give us no information about them. The *rainfall* is generally given; but this is no kind of test of the humidity of the atmosphere; nor does the daily, monthly, or annual mean temperature throw any light on the second point. A medical weather record should show the diurnal maxima and minima on both the dry and wet bulb; the rainfall; the state of the sky (clear or overcast); and the direction and force of the winds. These observations, properly digested, enable one to know how the climate will affect an invalid.

Analyses of the air of a locality have so far been of no medical utility. A current prepossession in favor of "the balsamic atmosphere of the pine woods" prevails as a prejudice rather than a proven fact. The rarefied atmosphere of mountain tops is just now highly popular for phthisis, as, some thirty years ago, the salubrious air of the nitre caves of Kentucky had its turn in general favor.

Ozone, which for a while seemed to be the desirable element, has fallen quite into disfavor, and even suspicion. It seems to have, on divers occasions, kept suspicious company with traveling epidemics.

The question, we think, narrows itself down, *ceteris paribus*, to a stable climate of slight humidity. Of course, there are certain diseases, especially of the circulatory and nervous systems, prone to over-stimulation, wherein this rule will not apply; but these constitute the small minority of health seekers.

Notes and Comments.

Camomile and Arnica.

These famous ancient remedies have fallen much into disuse. But a reviewer in the *Practitioner* says:—"We have been steadily trying the camomile oil. We can assert that this is a very powerful drug, and in many cases of heightened reflex irritability has proved of great service. In a very unusually severe case of mingled chorea and epilepsy in a middle-aged man, we have recently put camomile to what may be called a crucial test; and although the disease was necessarily incapable of complete cure, the amelioration has been very striking, and has been warmly acknowledged by the unfortunate patient."

Dr. Thorowgood, in a late work, points out that the erysipelatoid eruptions, etc., which have discredited arnica as a remedy for bruises, have been caused by lotions made with the alcoholic tincture: and he expresses the opinion that a great blunder has been habitually committed by those who have employed alcoholic

solutions of arnica for this purpose. The really active ingredient he considers to be trimethylamine, which has of late been attracting so much attention abroad. Now, alcohol extracts hardly any of this substance, but it is perfectly soluble in water: and on the other hand, the spirit does extract arnicine and an irritant oil, which are not present in the aqueous solution.

Procedure to Check Hemorrhage.

Dr. Vanzetti, the well-known surgeon of Padua, has just published a pamphlet, wherein he advises the following procedure to stop troublesome bleeding:—Two vulsella should be thrust on either side of the bottom of the wound giving blood, and deep enough to compress in their hooks the vessel which has been wounded. The hemorrhage may be stopped by drawing the lips of the wound asunder, just as is done for the removal of an ordinary tumor. This operation should be kept up for twenty-four, thirty, or forty hours, according to the size of the artery; and a thread, either elastic or not, should be passed under the seat of the hemorrhage.

Mr. Erichsen on American Surgery.

On November 9th, Mr. Erichsen delivered an address in London, on his impressions of American surgery during his late tour in this country. It is in general favorable, as may be judged from the following extract:—

Surgery in the United States certainly stands at a very high level of excellence. The hospital surgeons throughout the country have struck me as being alike practical, progressive, and learned in a very high degree. In practical skill, and aptitude for mechanical appliances of all kinds, they are certainly excelled by no class of practitioners in any country. They are thoroughly up to modern surgery in its most progressive forms, and I have never met with any class of men who are so well read and so perfectly acquainted with all that is done in their profession outside their own country. It would be a great injustice to American surgeons for it to be supposed that surgical skill is confined to the large cities, or to the few. On the contrary, I know no country in which, so far as it is possible to judge from contemporary medical literature, there is so widely diffused a high standard of operative skill, as in the country districts and more remote provinces of the United States. The bent of the mind of the American surgeon is, like ours, practical rather than scientific; in fact, there are the same mental characteristics displayed in him that we find here; the same self-reliance, the same practical aptitude, the same *curative* instinct, which leads him to consider his patient rather as a human being to be rescued from the effects of disease or injury, than as a scientific object to be studied for the advance of professional knowledge. How, indeed, can it be otherwise than that there should be such a resemblance?

Trichina in American Pork.

We see in the *Allgemeine Medicinische Centralzeitung*, Oct. 14, that Dr. Röper has examined a number of American sugar-cured hams sent to Germany, and finds three per cent. of them trichinous. Twenty people were sickened in Bremen, this fall, by these hams.

Influence of Chloroform in Labor on the Fœtus.

The Doctor mentions that Dubois says that when the mother is put under chloroform the fœtal heart is made more rapid. Dr. Zwefel, of Strasburg, gave chloroform for fifteen minutes to a patient, and she was confined two hours subsequently. The afterbirth had distinct reaction of chloroform in it. He also found chloroform in the urine of the child.

Mercurial Ointment in Boils and Carbuncles.

Dr. T. Roth lauds, in the *Deutsche Klinik*, the local application of gray ointment in boils and carbuncles, especially the early stages. He anoints the affected part with the ointment four times daily, and thereby reduces the inflammation and "backens" the boil most satisfactorily.

A Cure for Bright's Disease.

Dr. Hegswald says, a half pint thrice daily, of a fresh infusion of the leaves of *Asplenium Scolopendrium*, L., is a most successful treatment in Bright's disease. This is the harts-tongue or spleenwort, and is said to be popular in Devonshire and elsewhere, for its medicinal virtues.

Tyndall off the Track Again.

Prof. Tyndall has, of late, a dangerous facility for running off the track. First he rushes into the theological arena with a materialistic theory; now he hastens to the London *Times* with a

most positive statement that typhoid fever is not spontaneously generated by the decomposition and putrefaction of animal and vegetable substances, but is propagated solely through the medium of matter which has already been in contact with a typhoid patient. The "living human body is the soil in which the specific poison of typhoid fever breeds and multiplies."

Of course, he is now as thoroughly pummeled by English sanitarians as he was a month or two ago by the divines. Deservedly so. *Ne sutor ultra crepidam.*

CORRESPONDENCE

Atmospheric Pressure in Obstetrics.

ED. MED. AND SURG. REPORTER: —

I was shown, a few days since, an instrument invented and perfected by Dr. H. L. Stillman, of Usquepaugh, R. I., for use in place of forceps in cases of childbirth delivery, by means of atmospheric pressure (suction). The instrument is composed of a peculiar constructed elastic cup, an air pump and side dilators. The elastic cup fits to the vertex or other favorable presenting portions of the child; the air being exhausted from this by means of the pump, holds firmly to the parts attached; the pump connected with this serves for exhausting the air from the cup, also as the handle for traction. The side dilators slide upon the barrel of the pump, and are expanded or contracted at will. They serve to let air in on the full surface of the cup, thereby increasing the atmospheric pressure; also to dilate the vagina, to render an easy passage of the head or other parts presenting.

Its advantages over the forceps are these: 1st. From its peculiar construction it is much quicker and easier introduced. 2d. It causes no pain or suffering to the mother, and is devoid of the dangers of the forceps. 3d. In vertex presentations (others of the head are rare) it has thus far proved to be devoid of danger to the child. 4th. It does not increase the transverse diameter of the head, the forceps do. 5th. From its easy introduction, without pain, its use is much oftener indicated than the forceps; any intelligent practitioner may use it. 6th. Not increasing the diameter of the head, but dilating the passages for it, it thereby facilitates a much easier delivery. The surface of the atmospheric pressure is about seven inches; allowing twelve pounds to the square inch, the full pressure on traction is eighty-four pounds, though usually requiring much less than this.

Providence, R. I. C. A. H.

[The idea of employing atmospheric pressure in this manner was first suggested by Sir James Y. Simpson. Practical difficulties of detail prevented its adoption. ED. REPORTER.]

How do the Spermatozoa Enter the Uterus.

ED. MED. AND SURG. REPORTER:—

In a communication to the *American Journal of Obstetrics*, November, 1874, "How do the Spermatozoa enter the Uterus," by Dr. I. R. Beck, of Indiana, he quotes from Dr. Wernich, of Berlin, as follows: "I hope to be able, in some future paper on this subject, to support and fully establish my conviction of the absolute necessity of the mechanism first under consideration." I take it for granted, that the mechanism under consideration, means this: "That at the time of a fruitful coition, very probably at the moment of the highest excitation and ejaculation, the uterus moves downward in the cavity of the pelvis, the os uteri opens itself to a certain extent, the semen is received into the os, and in this manner reaches the uterine cavity, *partly in a direct manner, and partly through the suction of the os and cervix uteri.*" (Italics mine).

Now, I would like these gentlemen to explain how the spermatozoa enter the uterus, at the time of a "fruitful coition," with some mechanical obstacle intervening between the os uteri and the virile organ.

I have been assured most positively, by women wearing a large globe pessary, which completely filled the vagina, that the instrument had not been removed from the time I introduced it to relieve the prolapsed uterus, until I was consulted as to the propriety of removing it, on account of pregnancy, which, I am positively certain did not exist at the time of introduction. Again, I am quite certain, from my own personal experience, that women can and do become pregnant without evincing any erotic excitement during sexual intercourse.

Meigs, in his work, "Females and their diseases," says, on page 1871, "that the pessary does not put a bar either to gestation or conception."

In the words of Prof. Bischoff, "I do not believe that we should overlook the fact, that though in all probability these processes may and do favor conception, they should not by any means be regarded as absolutely necessary to the normal occurrence of this condition."

S. B. FLOWERS, M.D.

Mt. Olive, N. C., Dec. 5th, 1874.

The Hash Question.

ED. MED. AND SURG. REPORTER:—

It may, perhaps, be considered audacious to challenge so high an authority as Professor Redfern (see REPORTER, Oct. 10, p. 298), in regard to a subject in such bad odor, universally, as hash. The Professor seems to have in his mind the badly prepared dish as found in third-rate boarding houses and in families where the proper preparation of food is ignored. Hash may, of course, be indigestible and innutritious, and so may the best tender-loin steaks, if fried or stewed until all of the juices are wasted and the meat hardened.

Hash is a favorite among those thrifty housewives who would willingly utilize those bits of steak and roast beef, which are often left after the regular meal, and which it would be sinful to throw away. In such cases we think that the meat is better cut or chopped up with a little potato, parsley and onion, if desired, and served as a hash, than in any of the meat pies and other incongruities which have now become a by-word and a reproach among all classes of Americans, and it seems of English society.

Of course, a hash prepared out of meat once cooked, should be neither boiled nor stewed, but the gravy should be first prepared, and the finely cut onions, etc., thoroughly cooked, and then poured over the meat, which should be allowed to stand in the gravy, covered, and slowly heat through. This, when made of a piece of rare-done steak or roast beef, is a delicious breakfast dish, and less expensive pieces of beef may be first broiled without trouble, and then made, by this process, not only palatable but nutritious. It is high time that we, as a nation, should know how to economize, and not to be found daily guilty of casting into our slop buckets what would furnish a respectable family in Germany or France with a substantial diet. In these days of sanitary and hygienic excitement we are happy to see that there is a tendency to begin at the kitchen, rather than in the laboratory of the pharmacist, and that those of us who are not rapidly successful in earning a living, may, by aid of well directed periodicals, teach ourselves to save at least half a one. Yours, respectfully, M. A. B., M. D.

Philadelphia, November, 1874.

News and Miscellany.

Medical Night Watches.

A Berlin novelty is the establishment of "medical night-watches" (*Sanitätswachen*), *i.e.*, stated places in every quarter of the town where a doctor and his assistants are to be found at all hours of the night, to afford gratuitous assistance to any who need it. The duties of these medical men are by no means light. Not only are they sometimes almost overwhelmed with the number of persons seeking their aid, but they have also sometimes to call in the police to protect them from drunkards and disorderly persons. Vagabonds, too, often endeavor to get from them a lodging for the night. There have been great complaints from those who have undertaken these duties, that other doctors, when called to a case in the night, send the messengers who disturb them to the medical night-watch, saying they are established with that view; the fact being that they are only intended for the succor of those actually taken ill in the street. Hence there is no longer the same readiness on the part of the profession to undertake such posts, and there is great reason to fear that this most useful institution will die out.

Reporting Epidemic Diseases.

The Board of Health of this city have passed the following:—

Resolved, that the Health Officer be informed, that Medical Reports of all cases of the following diseases, or of any other diseases which may at any time hereafter assume, either generally or in some particular locality, a pestilential character, would meet the requirements of the Board, in the matter of pestilential or contagious diseases, viz: Asiatic Cholera, Relapsing Fever, Yellow Fever, Typhus or Ship Fever, Cerebro-spinal Meningitis or Spotted Fever, Small-pox and Varioloid, Scarlet Fever and Diphtheria.

Danger from Excavations.

It is well known that the exposure of large quantities of fresh earth, as attends railroad and canal construction, develops intermittent and typho-malarial fevers. To lessen this, Dr. Stephen Smith, of New York City, offers the wise recommendation that sewers be laid only after November 15, and before June 1; and last Tuesday week the Board of Health, accordingly, resolved that the Commissioner of Public Works be requested to omit all excavations between June 15 and October 1, and that no subsoil be exposed during that time.

Bronze Statue of a Philanthropist.

Mrs. Bartlett's statue of Dr. Wells, the discoverer of anæsthesia, is to be cast in bronze, in one piece, and set up at Hartford, just as it comes from the mould.

Items.

—The death is announced, on the 6th inst., of Dr. Friedrich Rochleder, Professor of Chemistry in the University of Vienna. A pupil of Liebig's, Rochleder was Professor of Chemistry at Prag for many years, and at Vienna since 1870. His lectures in the new laboratory of the latter University were much frequented by the students.

—There died recently, in Union township, Berks county, a young man, named William Kupp, aged 25 years, who weighed nearly 500 pounds. When last ascertained he weighed 468 pounds, and since then had increased considerably. He was 6 feet 2 inches high.

—A young Frenchman bet he could smoke twelve cigars consecutively. He won his bet, and had a handsome funeral three days afterwards.

—In Bremen, the city government has appointed a committee to make public arrangements for cremation.

—Chloral, it is said, will render a fiery horse quite lazy and sleepy, so as to give no trouble to the driver.

—Munich is about to have a Hygienic Institute, at the cost of 200,000 guldens.

Politics in Paris.

We called attention, some weeks ago, to the unpleasant reception given by the Parisian Medical Students to Professor Chauffard. The scene is thus described by a correspondent:—

"When the professor entered the room, accompanied by the dean, he was greeted with a tremendous noise, amongst which the cries of 'A bas les Royalistes,' 'A bas les cléricaux,' were loudly prominent. For several minutes the professor was unable to speak, his voice being drowned by the din each time he attempted to make himself heard, and as, notwithstanding the dean's strenuous efforts, nothing would induce the audience to be silent, Mr. Chauffard withdrew in company with the dean. After quoting the cries which were proffered on the occasion, it is scarcely necessary to say what was the object of this new manifestation of the students. Mr. Chauffard is accused of being kindly inclined in his opinions to the 'throne and the altar,' and a report circulated recently as to his possible appointment to the deanship of the school."

Philadelphia County Medical Society.

The next conversational meeting will be held Wednesday, Dec. 23d, at 8 o'clock, P. M. Dr. J. M. Boisnot will read a paper, entitled, "A Case of Purpura Hæmorrhagica Requiring Transfusion." All regular practitioners in the city are cordially invited.

QUERIES AND REPLIES.

Should a Man with Gleet Marry?

Dr. F. R., of New Jersey.—To this general question, as you say, many text-books give no decided answer. In our opinion, *he should not.* As long as there is the least discharge, sexual intercourse is very apt to irritate the urethra, and bring on a subacute attack. In that condition, he could infect his wife. Professor Van Buren says, in his late work on the Venereal (p. 59), "Glee is contagious when purulent; the more copious and creamy the discharge, the greater its infecting power."

Dr. W. E. M., of Illinois.—Naphey's *Therapeutics* will not be ready till spring.

OBITUARY.

DR. SAMUEL MITCHELL SMITH

Died at Columbus, Ohio, November 30th. He was born at Greenfield, Ohio, November 28th, 1816. He received a classical education at Miami University, and graduated in medicine at the University of Pennsylvania, and practiced at Columbus. During the war Dr. Smith was appointed Surgeon General of Ohio by Governor Todd, and during his term had heavy work in sending surgeons to the field and attending to his large general practice. He worked with unceasing energy, but overwork was the cause of the loss of the sight in one eye. During his official term he visited the fields of Antietam and South Mountain. Among his other services of a public character, Dr. Smith was appointed Examiner of Pensions, and while in the performance of his duties kept a valuable record of different accounts of battles from soldiers applying for pensions. He was also Physician to the Institution for the Deaf and Dumb.

DR. D. STAHL.

At Baden Baden, Germany, on the 26th of October, Dr. D. Stahl. Dr. Stahl was for many years a resident of Quincy, Illinois, and was well known and highly respected. He left Quincy for Germany about three years ago, and has been in Europe ever since. The report of his death will be read with sincere regret by very many of our readers who knew and honored him in the army. The deceased was 70 years of age.

MARRIAGES.

CULL—KENNEDY.—At Cambridge, New York, Nov. 26th, by Rev. J. Gardner, assisted by Rev. Dr. Sheldon, of Troy, Rev. Thomas Cull, of Middletown, Ohio, formerly of Poultney, and Mrs. Fanny Gray Kennedy, daughter of Dr. H. C. Gray, of Cambridge.

EARLE—WELLS.—In Brooklyn, on Thursday, Nov. 26th, at the residence of the bride's father, by Rev. R. S. Storrs, D. D., assisted by Rev. George L. Chase, of Faribault, Minnesota, Howard Earle and Annie Richardson, daughter of Dr. P. P. Wells, all of Brooklyn.

HYSKELL—MCCLURE.—November 26th, by the Rev. J. C. Wilhelm, W. D. Hyskell, M. D., of Orbisonia, Pa., and Sue A. McClure, of Petersburg, Huntingdon county, Pa.

REED—HOWARD.—On Saturday, November 28th, at the Church of the Holy Trinity, Brooklyn, by the Rev. Chas. H. Hall, D. D., Henry B. Reed, M. D., of Philadelphia, and Bertha O., daughter of Samuel E. Howard, of Brooklyn.

SMITH—DINGES.—At St. Michael's Church, Baltimore County, Md., on Tuesday, November 10th, by Rev. Dr. Rich, the Rector, assisted by Rev. W. A. Mitchell, of Hagerstown, Dr. C. W. Smith, of Nashville, Tennessee, formerly of Hagerstown, and Mary C. Dinges, of Baltimore county.

STENNIS—ADAMS.—On Tuesday morning, November 3d, by the Rev. D. S. W. Ellis, Dr. S. D. Stennis, of Moscow, Mississippi, and Janie, daughter of Mrs. Anna J. Adams of Moscow, Mississippi.

WHITNEY—HURD.—In Brooklyn, Tuesday, Nov. 24th, by Right Rev. Bishop Littlejohn, Albert D. Whitney, M. D., of New York, and Cordelia Coles, daughter of the late Dr. F. W. Hurd, of Brooklyn.

DEATHS.

CABELL.—November 7th, 1874, at the University of Virginia, Mrs. Margaret Nicholson Cabell, wife of Dr. James L. Cabell, and daughter of the late Col. John N. Gibbons, of Norfolk.

DARLING.—In Keene, New Hampshire, November 5th, of apoplexy, Caroline M., wife of J. Homer Darling, M. D., and daughter of the late Rev. A. W. Burnham, D. D., formerly of Rindge.

HOVEY.—On Wednesday, November 18th, at 4½ o'clock P. M., of typhoid pneumonia, at his residence in Cumminsville, Ohio, Dr. D. W. Hovey, aged 65 years.

SHELDON.—At No. 39 West One Hundred and Twenty-eighth street, New York, suddenly, on Friday, 20th ult., of diphtheria, George Cornell, oldest son of Dr. H. Lawrence and Emma Bartow Sheldon, aged 7 years.

SIMMER.—In this city, on the 20th ult., Louisa, wife of Dr. Edwin Simmer, and daughter of Mrs. Louisa Grœble, after a short illness, aged 30 years and 3 months.

SLACK.—Of diphtheria, on November 19th, at Troutdale, New Jersey, Carrie, aged 6 years, and on November 24th, in Philadelphia, Theodore Zerega, aged 5 years, children of Thirza A. and the late Dr. J. H. Slack, of Troutdale, New Jersey.